a sufficient portion of the mucosa of the lower end for contact with the external surface of the upper end, he divided the lower stump longitudinally about 1 cm. from the end. The mucosa was then removed for about 0.5 cm., which was not difficult, with the proper fixation of the ureter. The renal end was then drawn into the vesical end by means of a mattress suture of catgut, which was introduced through the whole wall a few millimeters from the end of each stump, directly opposite the longitudinal incision, the sutures being tied on the outside of the lower stump. The longitudinal incision was then closed by two catgut sutures, and the transverse margin of the lower stump was sutured to the outer layer of the upper stump. A tampon was placed to prevent urinary extravasation, but it was not necessary and was soon removed. Almost two years later, it was established by ureteral catheterization that the urine came out of the left ureter rhythmically, and that the catheter passed without any signs of resistance at the site of the wound in the ureter. A search of the literature showed that Gubaroff had done a similar operation, but without removal of the mucous membrane. Death of the patient on the thirty-first day had no relation to the operation. A postmortem showed complete restitution of the ureter. Pozzi did an operation in which he tried to bring the connective-tissue surfaces together, but four or five months later a stricture was found in the ureter at the site of the operation. Forssel thinks that this operation is to be preferred to all others, when it can be carried out, because of its simplicity; because it provides immediately at the site of the wound a good hindrance to the escape of urine; it is well suited for a quick and safe adhesion of the apposed ends of the ureter; it makes only a small sacrifice of the length of the ureter; and it does not sacrifice the normal opening of the ureter into the bladder.

A Contribution on the Employment of the Tubular Speculum in Laparotomies.—NYSTRÖM (*Zentralbl. f. Chir.*, 1911, xxxviii, 1403) says, in connection with Kuhn's recent contribution on this method in the *Zentralblatt*, that Gärdland, of Stockholm, has been using for two years in cases of peritonitis, a rectal speculum, very similar to the instrument employed by Kuhn, and has been using it in the same manner for obtaining a deep view of the peritoneal cavity through a small incision in the abdominal wall. Nyström has been employing a modification of the usual tubular rectal speculum. The rounded end of the obturator fitting into the speculum is made of glass, and is carried to the bottom of the speculum by a narrow handle, which permits a view through the glass end when it is in position. The usual electric lamp can be employed for light. Through this glass window at the end of the speculum the introduction of the instrument can be controlled. Nyström is more conservative than Kuhn as to the availability of the instrument for a complete examination of the abdominal cavity. Omentum and mesentery can so obstruct the speculum as to make it difficult or impossible to see some parts of the abdomen. In one case with symptoms of peritonitis, which was at first taken to be one of cholecystitis, a small abdominal incision was made along the right costal margin, and the speculum introduced. The upper part of the abdomen could be rather easily examined, but no focus for the peritonitis could be found, as the peritoneum was everywhere smooth and shining and showed no exudate. Then the speculum was passed to the middle and lower parts of the abdomen, but no exudate could be seen here, nor could the appendix or cecum be seen. Only after enlarging the wound and introducing the finger, was there found an infiltration behind the upper part of the ascending colon. Through an incision at a suitable place a gangrenous appendix with abscess was exposed and extirpated. With more experience, its usefulness will be increased and its limitations become better known. Even without a specially developed technique it is very serviceable. Several weeks before the reading of his paper, Nyström operated on a case of fracture of the pelvis with symptoms of rupture of the bladder, supposed to be on the anterior side. The prevesical space was opened by a median incision above the symphysis, and in the wound was found a considerable infiltration of urine. With the finger there was felt deeply a suspected place of rupture. With a small rectal speculum, without further enlargement of the wound, there was seen a small rupture, and through the speculum a Nélaton catheter was passed into the bladder. In order to exclude an intraperitoneal rupture, an incision was made in the peritoneum close to the bladder, wide enough only to pass the speculum. The posterior wall of the bladder and surrounding parts were examined. In the neighboring intestine and mesentery were found small hematomata, but the bladder wall was smooth and free of peritoneal irritation and exudate.

Concerning the Circular Suture of Vessels, Arteriovenous Anastomosis, and the Transplantation of Vessels.—YAMANOUCHI (*Deut. Zeit. f. Chir.*, 1911, cxii, 1) made an experimental study of bloodvessel suture, his observations being based upon 117 operations of various kinds. He says that arteries and veins divided transversely can be reunited very successfully. The healing at the line of sutures takes place by connective tissue, in which a part of the elements of the vessel wall is preserved in the line of union. The failures in circular suture are due to defects in the technique. For the filling in of an arterial defect from resection, a piece of vessel from the same individual is best suited. The transplanted vessel, whether artery or vein, lives permanently. If a vein is employed, it soon withstands the arterial blood pressure, because its wall increases in thickness. The healing at the line of sutures results from new tissue formed from the implanted and original vessel stumps, as well as from the perivascular tissue. The autoplastic implantation of a piece of vein into an artery is to be recommended as a surgical procedure, since the vein, even if it is larger, can be resected, as a rule, without noteworthy disturbances. It is, possible to transplant a piece of vessel into an arterial defect of another individual of the same or another species. The transplanted vessel, however, slowly disappears, and is substituted by the body tissues, so that finally it is surrounded by a connective-tissue tube, which is coated internally by epithelium developed from the ends of the stumps of the body vessel. The healing at the line of sutures takes place merely by growth from the body tissues, while the transplanted vessel remains wholly passive. In practice this method is not suitable, because dangerous complications may result, such as secondary